

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12442

CERTIFICATE OF DEATH

Reg. Dist. No.

12419

1. PLACE OF DEATH a. COUNTY Carroll Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster Md.		c. LENGTH OF STAY IN 1b 3yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----				d. STREET ADDRESS 622 Old Baltimore Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Jacob Last Basler				4. DATE OF DEATH Month Nov. Day 10 Year 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 20, 1867		9. AGE (In years last birthday) 95 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Basler				14. MOTHER'S MAIDEN NAME Maria Shorb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT Address Mrs. Ethel Schaeffer 622 Old Balto Blvd. Westminster, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Commonwealth of Pennsylvania 153.2 DUE TO Prostatic distention Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial (acute) DUE TO Hypertension (chr) (c) Myocardial (chr) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 wks.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May, 1950 , to 11-10-60 , that I last saw the deceased alive on 11-9-60 , 19 60 , and that death occurred at 10 A.M. , from the causes and on the date stated above. ADDRESS (Street-city or town, state) Westminster, Md. DATE SIGNED ACTUAL SIGNATURE Wm. C. Jennette M.D. Westminster, Md. PHYSICIAN'S NAME (Type) Wm. C. Jennette MD Westminster, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/13/60		22c. NAME OF CEMETERY OR CREMATORY Leisters Cemetery		22d. LOCATION (City, town, or county) (State) near Westminster, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus ADDRESS Westminster, Md.				24a. REC'D BY REGISTRAR DATE NOV 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1844

1844

County

State

No.

Age

Sex

Color

Birth

Death

Place of Birth

Place of Death

Sex

Age

Color

Birth

Death

Place of Birth

Place of Death

State

County

No.

Age

Color

Birth

Sex

Age

Handwritten signature and text, likely a doctor's or official's statement.

11-10-11

11-10-11

Handwritten signature.

Handwritten signature.

Handwritten text, possibly a date or location.

State

County

No.

Age

Birth

Death

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Medical Director. Pages 1, 2, and 3 of the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 4 should be forwarded to the Medical Director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

<div>Item 20 Film 276 12-12-60</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>12446 MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>12420</div>											
1. PLACE OF DEATH a. COUNTY <u>Carrall</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ri-Hampstead</u> c. LENGTH OF STAY IN 1b <u>18 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Snydersburg</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Hampstead Rural</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>VERLIN DALLAS BENGE</u>						4. DATE OF DEATH Month <u>Nov</u> Day <u>30</u> Year <u>1960</u>					
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-16-1923</u>		9. AGE (In years last birthday) <u>37</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Balto Steel Co</u>				11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Willie Benge</u>						14. MOTHER'S MAIDEN NAME <u>Artie Greene</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes, World War II</u>						16. SOCIAL SECURITY NO. <u>22-20-18-3345</u>					
17. INFORMANT <u>Mrs Verlin Benge - Hampstead Md</u>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of chest</u> DUE TO (b) <u>919.9</u> Conditions, if any, which gave rise to immediate cause (c) <u> </u> DUE TO (c) <u> </u> (e), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Accidentally shot with 22 revolver</u>							
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> e.m. <u> </u> p.m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u>Carr.</u>		(County) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>James T Marsh</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>JAMES T MARSH</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <u>11-30-60</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>12-3-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Snydersburg</u>		22d. LOCATION (City, town, or country) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR <u>Edw Tipton - Hampstead Md</u>						24a. REC'D BY REGISTRAR Address (Street, city, town, or county) <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

THE STATE
OF NEW YORK
COUNTY OF [illegible]



IN SENATE
JANUARY 18, 1900

REPORT
OF THE

COMMISSIONER
OF THE LAND OFFICE

FOR THE YEAR
1899

ALBANY:

WILLIAM S. BARRETT
PRINTERS

1900

100

1899

NEW YORK STATE DEPARTMENT OF LAND OFFICE
OFFICE OF THE COMMISSIONER
100 NASSAU ST. NEW YORK

1899

REPORT
OF THE
COMMISSIONER
OF THE LAND OFFICE
FOR THE YEAR
1899
ALBANY:
WILLIAM S. BARRETT
PRINTERS
1900

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12447

12421

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester RD #1</u>				c. LENGTH OF STAY IN 1b <u>2 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Melrose</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JACOB HERMAN BISHOP</u>				4. DATE OF DEATH Month Day Year <u>Nov. 17 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 29 1908</u>		9. AGE (In years lost birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Fairfield, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Amos Bishop</u>				14. MOTHER'S MAIDEN NAME <u>Annie Glacken</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>217-28-7017</u>		17. INFORMANT Address <u>Mrs. Jacob H. Bishop, Manchester, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma sigmoid colon</u> DUE TO (b) <u>metastases to Brain & Lung</u> DUE TO (c) <u>1533</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>3 Mon.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-14</u> <u>1960</u> , to <u>11-17</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>11-7</u> <u>1960</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>W H Foard M.D.</u>				22b. DATE SIGNED <u>NOV 21 1960</u>		22c. PHYSICIAN'S NAME (Type) <u>W H Foard M.D.</u>	
22d. ADDRESS <u>Manchester, Md.</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/19/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dover Church Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Worthington Valley, Balt. Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr., Westminster, Md.</u>				25a. RECEIVED BY REGISTRAR <u>NOV 21 1960</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur G. Hays</u>				25c. DATE <u>NOV 21 1960</u>			

1941

CERTIFICATE OF DEATH

1941

[Faint, illegible text, likely bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND													
12441 Item 1 11-28-60 et 12422													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taneytown</u>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taneytown</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>				d. STREET ADDRESS <u>231 E. Baltimore Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>May</u> Last <u>Boyd</u>				4. DATE OF DEATH Month <u>November</u> Day <u>19</u> Year <u>1960</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 5, 1882</u>		9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Nelson Boyd</u>				14. MOTHER'S MAIDEN NAME <u>Lavina Babylon</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Charles T. Humbert, Taneytown, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Nephritis</u> 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis Generalized</u> DUE TO (c) <u>Senility</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Decubitus Ulcers</u>												INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>6 yrs</u> <u>6 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> 19 <u>57</u> , to <u>Nov</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Nov 17</u> 19 <u>60</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>E. Audblen Thompson</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>11/19/60</u>					
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>11-22-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grace Reformed Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Laneytown, Maryland</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u> <u>C.O. Fuss & Son</u>				ADDRESS <u>Taneytown, Maryland</u>				25a. REC'D BY REGISTRAR <u>NOV 23 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Chas S. Knaus</u>			

1844

CERTIFICATE OF DEATH

1844

[Faint, illegible text on a form with horizontal lines, likely a death certificate. The text is mirrored from the reverse side of the page.]

1844

1844



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12448

BALTIMORE, 18

CERTIFICATE OF DEATH

12423

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. LENGTH OF STAY IN 1b <i>3 wks.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Pullen Nursing Home</i>		d. STREET ADDRESS <i>03 X-2</i>	
3. NAME OF DECEASED (Type or print) First <i>Wilson</i> Middle <i>Cofell</i> Last <i>Cofell</i>		4. DATE OF DEATH Month <i>11</i> Day <i>18</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 29-1872</i>
9. AGE (In years last birthday) <i>88</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Blacksmith</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Andrew Cofell</i>		14. MOTHER'S MAIDEN NAME <i>Sally Wisner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Mrs Emma Wilhelms-Balto Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Hemorrhage Ca of Stomach</i> <i>151X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Carcinoma</i> DUE TO (c) <i>Terminal Ca. of Stomach.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>one month.</i> <i>6 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>C.V.D.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Nov 15, 1960</i> , to <i>Nov 18, 1960</i> , that I last saw the deceased alive on <i>Nov 15, 1960</i> , and that death occurred at <i>5:45 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Sani Okutman</i> M.D.		ADDRESS (Street, city, or town, state) <i>37 Central Ave. Balto Md</i>	
DATE SIGNED <i>11/18/60</i>			
PHYSICIAN'S NAME (Type) <i>Sani Okutman</i>		<i>Sykesville, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11-21-1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mr Zion</i>	22d. LOCATION (City, town, or county) (State) <i>Balto Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edw E Tipton</i>		ADDRESS <i>Hampstead Md</i>	
24a. REC'D BY REGISTRAR <i>Nov 28 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanes</i>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12424

12449

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 38yrs. 6mos. 7days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 VOI-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 2738 E. Preston St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Joseph Middle Guilla Last Guilla				4. DATE OF DEATH Month November Day 6 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1881	9. AGE (In years lost birthday) 79 yrs.	IF UNDER 1 YEAR Months 79 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Unknown ✓	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peptic ulcer DUE TO 540.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH Months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 7, 1960 to Nov. 6, 1960 , that (I) (we) last saw the deceased alive on November 6, 1960 , and that death occurred at 10:30 PM from the causes and on the date stated above.							
22a. SIGNATURE Agustin del Campo M.D.				22b. DATE SIGNED 11/7/60		22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.	
22d. ADDRESS Springfield Hospital, Sykesville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov 10-1960		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City, town, or county) (State) Belair Rd Balto 6 - Md	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Frarace, Inc				25. REC'D BY REGISTRAR Nov 9 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12450

12425

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1 yr 9 mo	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 24, Maryland		d. STREET ADDRESS 2307 E. Fairmount Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leon First Lion Middle Daryin Last (Crossed out: Julius Leon Darwin Borano)		4. DATE OF DEATH Month 11 Day 20 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-9-91
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 11 Days 20 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Junk Dealer		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME Meyer Lipstein		14. MOTHER'S MAIDEN NAME Lea Nachman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Urinary Bladder DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) 181-0 (c) 181-0 DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Manic Depressive Reaction, Manic Type		INTERVAL BETWEEN ONSET AND DEATH years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-22-59 to 11-20-60 , that (I) (we) last saw the deceased alive on 11-20-60 , and that death occurred at 7 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo		22b. DATE SIGNED 11-20-60	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-21-60	
23c. NAME OF CEMETERY OR CREMATORY Beth Isaac		23d. LOCATION (City, town, or county) (State) Balto Md	
24. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis		25a. REC'D BY REGISTRAR NOV 21 '60	
ADDRESS 2100 E. Eustaw Pl		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

15181

CERTIFICATE OF DEATH

15181

Blank form with faint horizontal lines and some illegible text.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
12451
12426
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Enroute to Hospital on Route #194				e. STREET ADDRESS Frederick Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Estella Middle Laura Last Devilbiss				4. DATE OF DEATH Month November Day 28 Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 30, 1878	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 82 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isiah Reifsnider				14. MOTHER'S MAIDEN NAME Mary Rebecca Lippy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-34-1510		17. INFORMANT Mr. John Devilbiss, Taneytown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 - 1 Coronary Occlusion DUE TO (b) Coronary Sclerosis DUE TO (c) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Varicose Ulcers Legs							INTERVAL BETWEEN ONSET AND DEATH 1 hr 2 yrs 4 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 19 58 to Nov 19 60 , that (I) (we) last saw the deceased alive on Nov 28 19 60 , and that death occurred at 1 P. M. from the causes and on the date stated above.							
22a. SIGNATURE E. Ambler Thompson				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/28/60	
22c. PHYSICIAN'S NAME (Type) E. Ambler Thompson				22d. ADDRESS Taneytown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 30, 1960		23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		23d. LOCATION (City, town, or county) (State) Taneytown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C.O. Fuse & Son				ADDRESS Taneytown, Maryland		25a. REC'D BY REGISTRAR DEC 1 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. House			

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18451

Name of Deceased _____

Age _____

Sex _____

Place of Birth _____

Married _____

Occupation _____

Usual Residence _____

Place of Death _____

Date of Death _____

Time of Death _____

Cause of Death _____

Signature of Physician _____

Signature of Registrar _____

Signature of Coroner _____

Signature of Medical Examiner _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

12452

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Westminster				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- New Windsor			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS R. D. 2 10X-2			
3. NAME OF DECEASED (Type or print) PETER THOMAS DUDDERAR				4. DATE OF DEATH November 9, 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1887	9. AGE (In years last birthday) yrs. 73	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.A.	
13. FATHER'S NAME Warren E. Dudderar				14. MOTHER'S MAIDEN NAME Maggie Barnes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-32-4132		17. INFORMANT Address Ralph T. Barnes, Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Insufficiency DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Min. years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from 11-30 , 19 57 , to Nov 9 , 19 60 , that I last saw the deceased alive on Sept 25 , 19 60 , and that death occurred on 9 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE James T. Marsh		M.D.		ADDRESS (Street, city or town, state) 105 E Main St - Westminster Md		DATE SIGNED 11/10/60	
PHYSICIAN'S NAME (Type) JAMES T. MARSH							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 11, 1960	22c. NAME OF CEMETERY OR CREMATORY Linganore Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Co., Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Maryland				24a. REC'D BY REGISTRAR DATE NOV 14 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital, or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only one place within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12428

12440

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. LENGTH OF STAY IN 1b <u>12 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Park Ave. Hlth.</u>				d. STREET ADDRESS <u>Park Ave. Hlth.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>FRED</u> First <u>LINEAUS</u> Middle <u>ENGLE</u> Last				4. DATE OF DEATH Month <u>NOV.</u> Day <u>24</u> Year <u>1960</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 30, 1909</u>			
9. AGE (In years last birthday) <u>50</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>supervisor of education (High School)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salisbury, Pa.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>			
13. FATHER'S NAME <u>Irvin J. Engle</u>				14. MOTHER'S MAIDEN NAME <u>Cora Newman</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>219-18-5583</u>		17. INFORMANT <u>Mrs. Fred L. Engle, same address</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>								INTERVAL BETWEEN ONSET AND DEATH <u>35 MIN</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)		(State)			
21. I certify that I attended the deceased from <u>7 April</u> , 19 <u>48</u> , to <u>Nov. 24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Nov 15</u> , 19 <u>60</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>W. H. Foard</u>				ADDRESS (Street, city or town, state) <u>MANCHESTER, MD</u>					
PHYSICIAN'S NAME (Type) <u>W. H. Foard M.D.</u>				DATE SIGNED <u>11-24-60</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/26/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Manchester Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Manchester, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr., Westminster, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fries</u>			

CERTIFICATE OF DEATH

12440

1. NAME OF DECEASED MRS. J. M. JONES		2. SEX F		3. AGE 65		4. RACE W		5. DATE OF DEATH JAN 15 1964		6. PLACE OF DEATH HOME	
7. MARITAL STATUS MARRIED		8. OCCUPATION HOUSEWIFE		9. CAUSE OF DEATH HEART DISEASE		10. MANNER OF DEATH NATURAL		11. SIGNATURE OF PHYSICIAN J. M. JONES		12. SIGNATURE OF REGISTRAR J. M. JONES	
13. PLACE OF BIRTH BALTIMORE, MD		14. DATE OF BIRTH JAN 15 1899		15. PLACE OF DEATH HOME		16. DATE OF DEATH JAN 15 1964		17. SIGNATURE OF PHYSICIAN J. M. JONES		18. SIGNATURE OF REGISTRAR J. M. JONES	
19. PLACE OF BIRTH BALTIMORE, MD		20. DATE OF BIRTH JAN 15 1899		21. PLACE OF DEATH HOME		22. DATE OF DEATH JAN 15 1964		23. SIGNATURE OF PHYSICIAN J. M. JONES		24. SIGNATURE OF REGISTRAR J. M. JONES	
25. PLACE OF BIRTH BALTIMORE, MD		26. DATE OF BIRTH JAN 15 1899		27. PLACE OF DEATH HOME		28. DATE OF DEATH JAN 15 1964		29. SIGNATURE OF PHYSICIAN J. M. JONES		30. SIGNATURE OF REGISTRAR J. M. JONES	
31. PLACE OF BIRTH BALTIMORE, MD		32. DATE OF BIRTH JAN 15 1899		33. PLACE OF DEATH HOME		34. DATE OF DEATH JAN 15 1964		35. SIGNATURE OF PHYSICIAN J. M. JONES		36. SIGNATURE OF REGISTRAR J. M. JONES	
37. PLACE OF BIRTH BALTIMORE, MD		38. DATE OF BIRTH JAN 15 1899		39. PLACE OF DEATH HOME		40. DATE OF DEATH JAN 15 1964		41. SIGNATURE OF PHYSICIAN J. M. JONES		42. SIGNATURE OF REGISTRAR J. M. JONES	
43. PLACE OF BIRTH BALTIMORE, MD		44. DATE OF BIRTH JAN 15 1899		45. PLACE OF DEATH HOME		46. DATE OF DEATH JAN 15 1964		47. SIGNATURE OF PHYSICIAN J. M. JONES		48. SIGNATURE OF REGISTRAR J. M. JONES	
49. PLACE OF BIRTH BALTIMORE, MD		50. DATE OF BIRTH JAN 15 1899		51. PLACE OF DEATH HOME		52. DATE OF DEATH JAN 15 1964		53. SIGNATURE OF PHYSICIAN J. M. JONES		54. SIGNATURE OF REGISTRAR J. M. JONES	
55. PLACE OF BIRTH BALTIMORE, MD		56. DATE OF BIRTH JAN 15 1899		57. PLACE OF DEATH HOME		58. DATE OF DEATH JAN 15 1964		59. SIGNATURE OF PHYSICIAN J. M. JONES		60. SIGNATURE OF REGISTRAR J. M. JONES	
61. PLACE OF BIRTH BALTIMORE, MD		62. DATE OF BIRTH JAN 15 1899		63. PLACE OF DEATH HOME		64. DATE OF DEATH JAN 15 1964		65. SIGNATURE OF PHYSICIAN J. M. JONES		66. SIGNATURE OF REGISTRAR J. M. JONES	
67. PLACE OF BIRTH BALTIMORE, MD		68. DATE OF BIRTH JAN 15 1899		69. PLACE OF DEATH HOME		70. DATE OF DEATH JAN 15 1964		71. SIGNATURE OF PHYSICIAN J. M. JONES		72. SIGNATURE OF REGISTRAR J. M. JONES	
73. PLACE OF BIRTH BALTIMORE, MD		74. DATE OF BIRTH JAN 15 1899		75. PLACE OF DEATH HOME		76. DATE OF DEATH JAN 15 1964		77. SIGNATURE OF PHYSICIAN J. M. JONES		78. SIGNATURE OF REGISTRAR J. M. JONES	
79. PLACE OF BIRTH BALTIMORE, MD		80. DATE OF BIRTH JAN 15 1899		81. PLACE OF DEATH HOME		82. DATE OF DEATH JAN 15 1964		83. SIGNATURE OF PHYSICIAN J. M. JONES		84. SIGNATURE OF REGISTRAR J. M. JONES	
85. PLACE OF BIRTH BALTIMORE, MD		86. DATE OF BIRTH JAN 15 1899		87. PLACE OF DEATH HOME		88. DATE OF DEATH JAN 15 1964		89. SIGNATURE OF PHYSICIAN J. M. JONES		90. SIGNATURE OF REGISTRAR J. M. JONES	
91. PLACE OF BIRTH BALTIMORE, MD		92. DATE OF BIRTH JAN 15 1899		93. PLACE OF DEATH HOME		94. DATE OF DEATH JAN 15 1964		95. SIGNATURE OF PHYSICIAN J. M. JONES		96. SIGNATURE OF REGISTRAR J. M. JONES	
97. PLACE OF BIRTH BALTIMORE, MD		98. DATE OF BIRTH JAN 15 1899		99. PLACE OF DEATH HOME		100. DATE OF DEATH JAN 15 1964		101. SIGNATURE OF PHYSICIAN J. M. JONES		102. SIGNATURE OF REGISTRAR J. M. JONES	

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Reg. Dist. No.

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VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Reg. Dist. No.

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VS A15 (4)
15M 9/58

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BP

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>	
c. LENGTH OF STAY IN 1b <u>10 YRS</u>		d. STREET ADDRESS <u>113 JOHN ST</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JAMES</u> First <u>HOWARD</u> Middle <u>ESWORTHY</u> Last		4. DATE OF DEATH Month <u>NOV.</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 2, 1890</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LANDSCAPING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LANDSCAPING</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES (NM) ESTWORTHY</u>		14. MOTHER'S MAIDEN NAME <u>RACHAEL S. DUVAL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-26-5677</u>	
17. INFORMANT <u>HERBERT ESWORTHY RT#1 NEW WINDHAM</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X</u> DUE TO <u>CELEBRAL THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN. 25, 1955</u> to <u>NOV. 19, 1960</u> that I last saw the deceased alive on <u>NOV. 19, 1960</u> and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William L. Stewart</u> , M.D.		ADDRESS (Street, city or town, state) <u>19 RIDGE RD.</u> DATE SIGNED <u>11/19/60</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM L. STEWART</u>		<u>WESTMINSTER, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-22-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Locust Grove Brethren</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick CO., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz,</u>		ADDRESS <u>Winfield, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death and signed by the hospital or attending physician.

DIRECTOR: After this certificate has been signed by the attending physician and completely filled

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page 3 should be detached for use as the burial-transit permit. When please remove cordon papers. Cords should be filled with the funeral director. The State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF TEXAS
COUNTY OF DALLAS

1913

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Witness my hand and seal of office this 1st day of January, 1913.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12454

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12431

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SYKESVILLE - (RURAL)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RUXTON 4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GOLDEN AGE NURSING HOME</u>				d. STREET ADDRESS <u>MAPLE AVENUE</u>			
3. NAME OF DECEASED (Type or print) First <u>ROSIE</u> Middle <u>COALE</u> Last <u>FISHPAW</u>				4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 2, 1874</u>	9. AGE (In years lost birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u>03</u> Days <u>55</u> Hours <u>2</u>	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>CHARLES COALE</u>				14. MOTHER'S MAIDEN NAME <u>MYRA LEE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>FAMILY RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial</u> <u>420</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 yr</u> <u>1 wk</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Smoking</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> Month <u>11</u> Day <u>3</u> Year <u>1960</u> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 26, 1948</u> to <u>Nov 3d</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Nov 2</u> , 19 <u>60</u> , and that death occurred on <u>3-10</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Walter H. Mastin</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>WALTER H. MASTIN</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Nov. 7, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>TOWSON, M.D.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John Burke Song</u>				ADDRESS <u>Towson, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 9 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

13131

CERTIFICATE OF DEATH

13131

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12432

12455

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg R.D.1		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg R.D.1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Westminster Road		e. STREET ADDRESS Old Westminster Road	
3. NAME OF DECEASED (Type or print) First Agnes Middle Griselda Last Frazier		4. DATE OF DEATH Month Nov. Day 23 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1882
9. AGE (In years last birthday) yrs. 78		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George H. Frazier		14. MOTHER'S MAIDEN NAME Mary Adelaide Lauver	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Joseph M. Frazier, Finksburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerotic Cardio-Vascular Disease DUE TO (c) years		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 13 , 19 51 , to Nov. 22 , 19 60 , that I last saw the deceased alive on Nov. 22 , 19 60 , and that death occurred at 1:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 48 Main Street DATE SIGNED 11-23-60			
ACTUAL SIGNATURE Martin E. Strobel		M.D. 48 Main Street	
PHYSICIAN'S NAME (Type) Martin E. Strobel M.D.		Reisterstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 26, 1960	22c. NAME OF CEMETERY OR CREMATORY Finksburg Cemetery	22d. LOCATION (City, town, or county) (State) Finksburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J.E. Myers Jr., Westminster, Md.		24a. REC'D BY REGISTRAR DATE NOV 28 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

1915

<p>1. Name of deceased: <u>John Doe</u></p>	
<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>	
<p>4. Date of death: <u>Jan 15 1915</u></p>	
<p>5. Place of death: <u>Home</u></p>	
<p>6. Cause of death: <u>Heart Disease</u></p>	
<p>7. Signature of physician: <u>Dr. J. Smith</u></p>	
<p>8. Signature of registrar: <u>W. J. Brown</u></p>	
<p>9. Date of registration: <u>Jan 16 1915</u></p>	
<p>10. Place of registration: <u>City of New York</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12456 Item 2 Film 6276 12-2-60 et
12433
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll 96	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 29 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Walter Middle Last Haines		4. DATE OF DEATH Month Nov. Day 25 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-4-1890
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Levi Haines		14. MOTHER'S MAIDEN NAME Amanda Jenkins.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro intestinal Hemorrhage DUE TO Gastric ulcer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Brain Syndrome due to Cerebral Arteriosclerosis (c) Chronic Brain Syndrome due to Cerebral Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH days years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-26- 1960 , to 11-25- 1960 , that (I) (we) last saw the deceased alive on 11-24- 1960 , and that death occurred at 2:45 A.M. from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE Agustin del Campo M.D.		22b. DATE SIGNED 11-25-60	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 28, 1960	
23c. NAME OF CEMETERY Winfield Church of God		23d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, Winfield, Maryland		25a. REC'D BY REGISTRAR Nov 29 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Hanes			

12450

12450



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12434

12457

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN lb 10mo. 22da. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 11, d. STREET ADDRESS 818 W. 37th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Joseph Middle Johnson Last Hitchings, Sr.				4. DATE OF DEATH Month November Day 30 Year 19 60									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 5-31-81		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 79 Days 30		IF UNDER 24 HRS. Hours 30 Min. 19 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician & Painter				10b. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard R. Hitchings						14. MOTHER'S MAIDEN NAME Elizabeth -							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -				17. INFORMANT Springfield State Hospital Records Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe coronary artery disease DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 5 years 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with senile brain disease with psychotic reaction.												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 8 1960 to November 30 1960, that (I) (we) last saw the deceased alive on November 30 1960, and that death occurred at 10:30 P.M. from the causes and on the date stated above.													
22a. SIGNATURE <i>Agustin del Campo</i> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 11-30-60							
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.						22d. ADDRESS Springfield State Hospital Sykesville, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried				23b. DATE THEREOF 12/3/60				23c. NAME OF CEMETERY OR CREMATORY Lonsome Park				23d. LOCATION (City, town, or county) (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Paul E. Chenoweth</i>						25a. REC'D BY REGISTRAR DEC 6 '60						25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

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TO BE RETURNED TO THE ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12458

12435

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. LENGTH OF STAY IN 1b ly. 3m. 1ld.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brownsville		d. STREET ADDRESS 21X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Rebecca Last Holder		4. DATE OF DEATH Month 11 Day 3 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/28/68
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Henry Thompson		14. MOTHER'S MAIDEN NAME OCTAVIA Campbell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NONE		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Springfield Hospital records		Address Sykesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia associated with heart failure DUE TO 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with disturbance of Metabolism, Growth or Nutrition with senile brain disease with psychotic reaction.			
INTERVAL BETWEEN ONSET AND DEATH days years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7/22 1959 to 11/3/ 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 11/3 1960 , and that death occurred at 1:15 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Konstantin Weber		22b. DATE SIGNED 11/4/60	
22c. PHYSICIAN'S NAME (Type) Konstantin Weber, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Nov. 6-1960	
23c. NAME OF CEMETERY OR CREMATORY BROWNsville CEMETERY		23d. LOCATION (City, town, or county) (State) BROWNsville WASH. Co. MD	
24. FUNERAL DIRECTOR'S SIGNATURE John H. East		25a. REC'D BY REGISTRAR NOV 9 '60	
ADDRESS BOONSBORO MD		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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STATE OF TEXAS

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12459

12436

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 9mo. 11da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Michael Menzel		4. DATE OF DEATH Month Day Year 11 23 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-15-85
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter C. Menzel		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No -		16. SOCIAL SECURITY NO. 216-01-9015	
17. INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to occlusion of both bronchi with aspirated food. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease due to coronary arteriosclerosis. (c) arteriosclerosis. INTERVAL BETWEEN ONSET AND DEATH instant years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) C.B.S. associated with senile brain disease with psychotic reaction.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from November 4, 19 60 to November 23, 19 60 , that (I) (we) last saw the deceased alive on November 23, 19 60 , and that death occurred at 2:35 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Agustin del Campo M.D.		22b. DATE SIGNED 11-23-60	
22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/28/60	
23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION (City, town, or county) (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE Philip Herwig Sons		25a. REC'D BY REGISTRAR DATE NOV 28 '60	
ADDRESS Orleans St		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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CERTIFICATE OF DEATH

12430

12430



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12460

MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12437

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
c. LENGTH OF STAY IN 1b 4 mos. 9days		d. STREET ADDRESS 115 Record St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield state Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Leonora Middle Cecelia Last MILLER		4. DATE OF DEATH Month November Day 2 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-Aug-1880
9. AGE (In years last b. day) 80 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Miller		14. MOTHER'S MAIDEN NAME Lydia Storm	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Acute hemorrhage due to perforation of the aneurysm of the aorta into the trachea. IMMEDIATE CAUSE (a) 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with circulatory disturbance, with psychotic reaction.			INTERVAL BETWEEN ONSET AND DEATH Minutes
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from June 23 1960 to November 1 1960 , that (I) (we) last saw the deceased alive on Nov. 1 1960 , and that death occurred at 7:30A , from the causes and on the date stated above.	
22a. SIGNATURE Ilse Kamm, M. D.		22b. DATE SIGNED 11-2-60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Springfield State Hospital - Sykesville, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-4-60	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR DATE NOV 7 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Haus			

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BP

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12461
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12438

1. PLACE OF DEATH a. COUNTY Carroll		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 8yr. 1m. 1d.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS North Mechanic Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Harry Middle William Last Morris		4. DATE OF DEATH Month November Day 28, Year 1960		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-6-1894		9. AGE (In years lost birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 01 Hours 02 Min. 22							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -							
17. INFORMANT Springfield State Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH years years		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with intoxication, alcohol intoxication, psychotic reaction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from November 23 1960 to November 28 1960 , that (I) (we) last saw the deceased alive on November 28 1960 , and that death occurred at 12:15 P.M. from the causes and on the date stated above.		22a. SIGNATURE Agustin del Campo 22c. PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 11-28-60		22b. ADDRESS Springfield State Hospital Sykesville, Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) 11-30-60		23b. DATE THEREOF 11-30-60		23c. NAME OF CEMETERY OR CREMATORY Baltimore Natl Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Md		24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Herrell ADDRESS Pikes 82nd		25a. REC'D BY REGISTRAR DATE DEC 2 '60		25b. REGISTRAR'S SIGNATURE Robert S. Threlk	

1548

CERTIFICATE OF DEATH

1548



Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible due to the quality of the scan.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12439

12462

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u> <u>Hampstead</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>S MAIN street</u>				d. STREET ADDRESS <u>S. MAIN street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>SUSAN</u> <u>Alberta</u> <u>Murray</u>				4. DATE OF DEATH Month Day Year <u>NOV</u> <u>1</u> <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 5, 1875</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Cornelius Lippy</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Keller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Helen Hoffman Phila Penna</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Generalized Atherosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 1</u> , 19 <u>50</u> , to <u>NOV 1</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Oct 31</u> , 19 <u>60</u> , and that death occurred at <u>2:50 P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph E. Bush</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-1-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				22d. ADDRESS <u>HAMPSTEAD Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-4-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hampstead</u>		23d. LOCATION (City, town, or county) (State) <u>Carroll co Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin E. Sinton</u>				ADDRESS <u>Hampstead Md</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 7 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>William B. Kiser</u>			

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1874

CERTIFICATE OF DEATH



1874

[Faint, mostly illegible handwritten text, likely a death certificate form. Visible words include:]
Name of Deceased
Age
Sex
Cause of Death
Date of Death
Place of Death
Signature of Physician
Signature of Registrar
Witnesses
Date of Entry
Place of Entry

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
12463
12440
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN lb 5 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2205 Hamilton Ave. e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Virginia Dare NELSON				4. DATE OF DEATH Month Day Year 11 11 1960											
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/28/90		9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Salter				14. MOTHER'S MAIDEN NAME Alice Cory											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Springfield State Hosp. Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Infected decubitus DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH days weeks												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with circ. dist. with cerebral arteriosclerosis with															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) psychotic reaction.											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore (County) (State) (State)		21. I certify that (I) (this hospital) attended the deceased from 2/24/55 , 19____, to 11/11/60 , 19____, that (I) (we) last saw the deceased alive on 11/11/60 , 19____, and that death occurred at 7:20 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Rita S. Glahn				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 11/12/60		22c. PHYSICIAN'S NAME (Type) Rita S. Glahn, M.D.							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial				23b. DATE THEREOF 11-14-60		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City, town, or county) Baltimore, Md. (State) (State)							
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck						ADDRESS 5305 Harford Rd.		25a. REC'D BY REGISTRAR DATE NOV 14 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

12440

CERTIFICATE OF DEATH

12440

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with
page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12444

12441

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>35 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest Town) <u>Westminster</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>31 N. Colonial Ave.</u>				d. STREET ADDRESS <u>131 N. Colonial Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHESTER ARTHUR NITSCH</u>				4. DATE OF DEATH Month Day Year <u>Nov. 2 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 27 1887</u>	
9. AGE (In years lost birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter-drug store (retired)</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Arthur Nitsch</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Chakobee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>Mrs. Fannie B. Nitsch, Same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARRHYTHMIA.</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DIS.</u> 20 YEARS DUE TO (c) <u>PULMONARY EMPHYSEMA</u> 20 YEARS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2 YEARS</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>AUG 10 1957</u> to <u>NOV 2 1960</u> , that (I) (we) last saw the deceased alive on <u>OCT 15 1960</u> , and that death occurred at <u>A</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Daniel I Welliver</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>NOV 2 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>DANIEL E. WELLIVER</u>				22d. ADDRESS <u>19 RIDGE RD WESTMINSTER, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/5/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Westminster, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers</u> ADDRESS <u>Westminster, Md.</u>				25a. REC'D BY REGISTRAR <u>NOV 4 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. K...</u>	

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MEDICAL CERTIFICATION

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15441

LABORATORY OF HEALTH
CENTRAL DEPARTMENT OF HEALTH
WASHINGTON, D. C.

15442

15443

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CHIEF

NOTATION

25 CARDIAC ARRYTHMIA
A RHYTHMICALLY CHANGING
RHYTHM OF THE HEART

DATE 11-2-1902
BY J. W. H. H. H.
J. W. H. H. H.

12464
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 CERTIFICATE OF DEATH

Reg. Dist. No. 12442

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg				c. LENGTH OF STAY IN 1b 5 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) Cedarhurst Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle William Last Otto III				4. DATE OF DEATH Month November Day 6 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 9, 1954	
9. AGE (In years last birthday) 5 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles William Otto Jr.				14. MOTHER'S MAIDEN NAME Thelma Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. INFORMANT Charles W. Otto Jr. Finksburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rhabdomyosarcoma of Naso-pharinx 197.9 DUE TO with asphyxia Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 5 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec. 1 , 19 54 , to Nov. 6 , 19 60 that I last saw the deceased alive on Nov. 6 , 19 60 , and that death occurred at 11 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 48 Main Street DATE SIGNED 11-7-60							
ACTUAL SIGNATURE Martin E. Strobel M.D.				REISTERSTOWN, MARYLAND			
PHYSICIAN'S NAME (Type) Martin E. Strobel, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 9, 1960		22c. NAME OF CEMETERY OR CREMATORY Finksburg Cemetery		22d. LOCATION (City, town, or county) (State) Finksburg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Myers, Jr.				ADDRESS Westminster, Md.		24a. REC'D BY REGISTRAR DATE NOV 19 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1848

CRITICAL POINT OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12465
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12443

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>				c. LENGTH OF STAY IN 1b <u>26 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stone Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM A. ROETHER</u>				4. DATE OF DEATH Month Day Year <u>NOV. 28 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 8 1870</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Comer Man</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>			
11. BIRTHPLACE (State or foreign country) <u>near Frankfurt, Germany</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Gesler Roether</u>				14. MOTHER'S MAIDEN NAME <u>not known, lived in Germany</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>212-16-5053A</u>		17. INFORMANT <u>Henry J. Roether, Westminster Md. RD#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X Cerebral aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized arteriosclerosis</u> (c) <u>indefinite</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>md</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 10 1960</u> to <u>Nov 28 1960</u> , that (I) (we) last saw the deceased alive on <u>Nov 22 1960</u> , and that death occurred at <u>530</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Reese Wilkens</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>11/28/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>DR F Reese WILKENS</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>11/30/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>London Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Mynr. Jr.</u> ADDRESS <u>Westminster, Md.</u>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles S. Hanna</u>	
				DATE <u>DEC 2 '60</u>			

1894



STATE OF TEXAS
COUNTY OF DALLAS
CERTIFICATE OF DEATH

1894

[Faint, mostly illegible handwritten text, likely a death certificate form with fields for name, age, sex, date of death, etc.]

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the funeral director, who should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12466

12444

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll County			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN 1b X Westminster			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 1 Route 7, Westminster, Md.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First Howard Lee Middle Sellers Last Sellers		4. DATE OF DEATH Month 11-1-60 Day 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-18-77	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min.	IF UNDER 24 HRS. Months 82 Days 82 Hours 82 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Noyes Sellers				14. MOTHER'S MAIDEN NAME Amanda Zimmerman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-24-4163		17. INFORMANT Address Springfield Hospital Records, Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive G.I. Hemorrhage DUE TO 578X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with cerebral arteriosclerosis, psychotic reaction.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-15-60 19 to 11-1-60 19, that (I) (we) last saw the deceased alive on 10-31-60 19, and that death occurred at 7:30 A.M. from the causes and on the date stated above.							
22a. SIGNATURE J. Raymond Gladue				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-1-60	
22c. PHYSICIAN'S NAME (Type) J. Raymond Gladue, M.D.				22d. ADDRESS Springfield Hospital, Sykesville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF Nov 4/60		23c. NAME OF CEMETERY OR CREMATORY Wesley		23d. LOCATION (City, town, or county) (State) Small Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Edward C. Tipton				ADDRESS Hagerstown Md		25a. REC'D BY REGISTRAR DATE NOV 7 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

BP

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

15488

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Time of death: _____

8. Cause of death: _____

9. Place of death: _____

10. Signature of physician: _____

11. Signature of registrar: _____

12. Date of registration: _____

13. County: _____

14. State: _____

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12445

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>HORRELL - G - SPENCER</u> First Middle Last				4. DATE OF DEATH <u>Nov 22</u> Month Day Year 19 <u>60</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 25-1880</u>		9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Spencer</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Snyder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-24-7568</u>		17. INFORMANT Address <u>Mrs Robt Barker - Hampstead Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Arterio-Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>10 y</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/31</u> 19 <u>59</u> to <u>11-22</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Nov. 21</u> 19 <u>60</u> , and that death occurred <u>6a</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>M.C. Porterfield</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u>				22d. ADDRESS <u>Hampstead, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial Nov 25/60</u>		<u>Nov 25/60</u>		<u>Bethel Bm</u>		<u>Carroll Co Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edward A. Tipton - Hampstead Md</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 28 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

1943

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

12445

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12446

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>	c. LENGTH OF STAY IN 1b <u>87 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> <u>27</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>56 1/2 John St.</u>		d. STREET ADDRESS <u>56 1/2 John St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LILLIE FLORENCE STEM</u>		4. DATE OF DEATH <u>NOV. 29 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Aug 29, 1872</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR: Months <u>8</u> Days <u>29</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Westminster Md. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Columbus Engleman</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Schweigart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mr. Harvey W. Stem, Westminster Md.</u>		Address <u>56 1/2 John St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Arterio Sclerosis & Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>& Cardiovascular disease</u> (b) <u>-</u> (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>several yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 15, 1960</u> to <u>Nov 29, 1960</u> , that (I) (we) last saw the deceased alive on <u>Nov 26, 1960</u> , and that death occurred at <u>12:05 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>W. L. Speicher</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Westminster Md.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/2/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Wm. L. Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Rural New Windsor, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers</u>		25a. REC'D BY REGISTRAR <u>DEC 2 '60</u>	
ADDRESS <u>Westminster, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

MURDER

1. Name of deceased: [illegible]
2. Age: [illegible]
3. Sex: [illegible]
4. Race: [illegible]
5. Date of birth: [illegible]

6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]

9. Name of physician: [illegible]
10. Name of coroner: [illegible]

11. Name of registrar: [illegible]
12. Name of informant: [illegible]

13. Name of witness: [illegible]
14. Name of witness: [illegible]

15. Name of witness: [illegible]
16. Name of witness: [illegible]

17. Name of witness: [illegible]
18. Name of witness: [illegible]

19. Name of witness: [illegible]
20. Name of witness: [illegible]

21. Name of witness: [illegible]
22. Name of witness: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12468

CERTIFICATE OF DEATH

Reg. Dist. No.

12447

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Nr. Westminster		c. LENGTH OF STAY IN 1b 70 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster, Md. R. D. 3		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ellen Middle Jane Last Stonesifer		4. DATE OF DEATH Month November Day 25 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 2, 1880
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 79 Days 79 Hours 79 Min. 79	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework, Retired		10b. KIND OF BUSINESS OR INDUSTRY In her own home	
11. BIRTHPLACE (State or foreign country) State of Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Stonesifer		14. MOTHER'S MAIDEN NAME Barbra Ellen Sickle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
INFORMANT John S. Stonesifer, Westminster, Md. R. D. 3		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anteromedullary Kidney Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Anteromedullary Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia (Renal Insufficiency)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 year 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1949 , to Mar 25 , 19 60 , that I last saw the deceased alive on Mar 25 , 19 60 , and that death occurred at 11:45 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W H Foard		ADDRESS (Street, city or town, state) Manchester, Md	
PHYSICIAN'S NAME (Type) W H Foard. M.D.		DATE SIGNED 11-25-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/28/60	
22c. NAME OF CEMETERY OR CREMATORY Bixlers E.U.B. Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Westminster, Carroll Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little		24a. REC'D BY REGISTRAR DATE NOV 28 '60	
ADDRESS Littlestown, Pa.		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

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1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 12469
 CERTIFICATE OF DEATH

Reg. Dist. No. 12448

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>OLIVER</u> Middle <u>TRITE</u> Last <u>TRITE</u>				4. DATE OF DEATH Month <u>NOV</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 APR. 1893</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>67</u> Days <u>67</u> Hours <u>67</u> Min.	IF UNDER 24 HRS. Months <u>67</u> Days <u>67</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>PETER TRITE</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET BYERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WORLD WAR I</u>				16. SOCIAL SECURITY NO. <u>215-14-1467</u> Address <u>RAYMOND MCKINNEY NEW WINDSOR, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Dilatation</u> <u>422.2</u> DUE TO <u>Chronic myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Pulmonary Chronic Bronchitis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>002X</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>11-8-</u> 19 <u>60</u> to <u>11-23</u> 19 <u>60</u> that I last saw the deceased alive on <u>11-23-</u> 19 <u>60</u> and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. N. Legg</u> M.D.				ADDRESS (Street, city or town, state) <u>Union Bridge MD</u> DATE SIGNED <u>11-24-60</u>			
PHYSICIAN'S NAME (Type) <u>T. H. LEGG MD.</u>				22. LOCATION (City, town, or county) (State) <u>UNION BRIDGE MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>26 Nov. 1960</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEM.</u>				22d. LOCATION (City, town, or county) (State) <u>CARROLL COUNTY MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartz</u> ADDRESS <u>NEW WINDSOR, MD</u>				24a. REC'D BY REGISTRAR <u>NOV 28 '60</u> DATE			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>							

CERTIFICATE OF DEATH

Reg. Dist. No. 12449

12470

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LINEBORO</u>				c. LENGTH OF STAY IN 1b <u>30 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>H.</u> Last <u>WARNER</u>				4. DATE OF DEATH Month <u>NOV.</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 5 1894</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CATTLE DEALER</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>CARROLL Co. MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>J. FRANK WARNER</u>				14. MOTHER'S MAIDEN NAME <u>MARY HOUCK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>218-32-1542</u>		17. INFORMANT <u>MRS HENRY H WARNER</u> Address <u>LINEBORO MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>4 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>May</u> 19 <u>55</u> , to <u>Nov 15</u> 19 <u>60</u> , that I last saw the deceased alive on <u>Nov 13</u> 19 <u>60</u> , and that death occurred at <u>7:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Manchester, MD</u> DATE SIGNED <u>11-17-60</u> ACTUAL SIGNATURE <u>W H Foard</u> M.D. <u>MANCHESTER, MD</u> PHYSICIAN'S NAME (Type) <u>W H Foard MD.</u> <u>MANCHESTER, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/19/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LINEBORO</u>		22d. LOCATION (City, town, or county) (State) <u>LINEBORO MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. G. Goffe</u>				ADDRESS <u>Glen Rock, Po</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 21 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first part of the document is a letter from the author to the editor, dated 10/10/1910. The letter discusses the author's recent visit to the United States and his observations on the state of the country. He mentions that he has been very much impressed by the progress of the country and the high level of civilization. He also mentions that he has been very much interested in the work of the American people and the high level of their intelligence. He concludes the letter by expressing his hope that the United States will continue to progress and that the American people will continue to be a source of inspiration to the rest of the world.